Depression Medication Pathway for Adults

The aim of this pathway is to encourage safe and efficient prescribing by advising the best evidence based pharmacological treatments for unipolar depression.

**Patients aged over 65 years:** Any doses stated refer to adult dosing and the prescriber should consult the BNF for advice on doses for elderly patient groups.

**Key prescribing guidelines**

* At all steps, consider non-pharmacological options instead of or in support of drug treatment, e.g. talking therapies
* Request a full list of medical problems and medication from the GP
* Consider causative underlying physical health problems
* Consider monotherapy first
* Before initiating treatment, explain the risk of discontinuation symptoms and how these can be minimised
* Medication trials should be at least 4 weeks at the maximum tolerable dose
* Combination or augmentation may be more effective when there is partial response
* Antidepressants used for alternative indications at low doses (e.g. trazodone to aid sleep) should be taken into consideration but are not considered combination treatment
* Any benzodiazepine or hypnotic prescription should be used with caution and short term use only (maximum 2 weeks)
* Deprescribing and Swapping & Stopping advice is provided [here](#_Consultation_and_Prescribing)

**Definitions**

* Combination – Two or more treatments, each of which represents an antidepressant alone, i.e. it adds an extra effect without altering the action of the first drug
* Augmentation - Augmentation means adding another drug that by itself is not an antidepressant, but that may improve the efficacy of the original antidepressant.
* Partial Response - Failure to respond completely to a course of single drug therapy
* Off-label - prescribing a licensed medication for a condition outside of their licence
* Unlicensed - prescribing a medicine that does not have a UK marketing licence

**Off-label and Unlicensed Medicines**

As you move through the steps, the choices are often off-label. This is highlighted next to each medication. Before prescribing off-label or unlicensed medicines the following conditions must be met:

* The medicine is better suited to the patient/client’s needs than an appropriately licensed alternative
* There is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
* The reasons why medicines are not licensed for their proposed use should be explained to the patient/client, or parent/carer
* A clear and accurate record of medicines and the rational for use should be documented on Paris (unless the medication is included in TEWV off-label permissions) as part of the Medication Treatment Plan
* Off-label and unlicensed medications monitoring and prescribing arrangements are likely to remain in secondary care unless transfer has been agreed

**Depression With Personality Disorder**

Manage as per depressive episode including psychological and pharmacological treatments. Consider diagnosis of co-morbid Depression

**(N) = recommended by NICE guidelines**

**\* = should only be initiated by a Consultant Psychiatrist or Level 3 Non-Medical Prescriber with competency to initiate the medication.**

**In need of ACTIVATION**

* Loss of interest
* Oversleeping
* Overeating
* Poor concentration
* Indecisive
* General slowing

**In need of SEDATION**

* Lack of sleep
* Lack of appetite
* Agitation/restlessness
* Suicidal thoughts
* Loss of libido\*

\* SSRI not primary choice

**SSRI (N) or low dose Venlafaxine**

* Sertraline initially 50mg, titrated to at least 100mg/day
* Venlafaxine up to 150mg/day

**Mirtazapine**

30mg AT NIGHT

(more sedating at 15mg)

Not ideal for patients concerned about weight gain

Reassess mood using interview and a validated rating scale

Check effects of medication and adherence

Reassess mood using interview and a validated rating scale

Check effects of medication and adherence

PARTIAL RESPONSE

Consider increase to maximum dose for further 6-week trial if tolerated

**General**

**Symptom**

**Profile**

**STEP 1**

Trial of single drug therapy – 4-6 weeks at treatment dose

**STEPS 2 & 3**

2 further trials of single drug therapy from different drug groups – 4-6 weeks at treatment dose

**CONSIDER (in any order)**

* + A different SSRI if the first is not tolerated **(N)**
* Increase venlafaxine to 150-375 mg/day or switch to duloxetine if not tolerated **(N)**
* [Vortioxetine](#Vortioxetine) **(N)** (if 2 previous failed or non-tolerated trials)

**CONSIDER (in any order)**

* Venlafaxine + hypnotic

(short term for sleep 2 weeks) **or** + trazodone 50-100 mg

* SSRI + hypnotic

(short term for sleep 2 weeks) **or** + trazodone 50-100 mg

* [Vortioxetine](#Vortioxetine) **(N)** (if 2 previous failed or non-tolerated trials)

Reassess mood using interview and a validated rating scale

Check effects of medication and adherence

Reassess mood using interview and a validated rating scale

Check effects of medication and adherence

PARTIAL RESPONSE

Consider increase to maximum dose for further 4–6-week trial if tolerated

**NO RECOVERY**

**NO RECOVERY**

**NO RECOVERY**

Consider seeking advice from a Specialist

**PARTIAL RECOVERY**

Add Psychological Therapy

if not already tried

**STEP 5**

Specialist Initiation/Recommendation

Consider in any order

4-6 weeks at treatment dose

**NO RECOVERY**

[**AUGMENTATION**](#Augmentation) **of partially effective antidepressants**

* [SSRI + buspirone](#SSRIplusBuspirone) up to 60 mg/day (licensed max. 45 mg/day)
* [Bupropion](#Bupropion)\* (off-label)

**STEP 6**

Secondary Care Only

**NO RECOVERY**

* ECT
* Transcranial magnetic stimulation
* Implanted vagus nerve stimulation
* [Agomelatine](#Agomelatine)\* (if 3 previous failed or non-tolerated trials)
* [Levothyroxine or Triiodothyronine (Liothyronine)](#Triiodothyronine) (off-label) **(N)**

**STEP 4**

Specialist Initiation/Recommendation

Consider in any order

4-6 weeks at treatment dose

**FURTHER LINE & CHRONIC DEPRESSION**

[**Combination**](#Combination) **of different antidepressants**

* [SSRI](#SSRIvenlafaxineDuloxetineMirtazapine" \o "SSRI or venlafaxine or duloxetine + mirtazapine) **[or](#SSRIvenlafaxineDuloxetineMirtazapine" \o "SSRI or venlafaxine or duloxetine + mirtazapine)** [SNRI + Mirtazapine](#SSRIvenlafaxineDuloxetineMirtazapine" \o "SSRI or venlafaxine or duloxetine + mirtazapine) **[(N)](#SSRIvenlafaxineDuloxetineMirtazapine" \o "SSRI or venlafaxine or duloxetine + mirtazapine)**
* [Mirtazapine **or** SSRI + Reboxetine](#MirtazapineorSSRIplusReboxetine) (2-8 mg daily)

**Mood Stabiliser** [**AUGMENTATION**](#Augmentation) **of partially effective antidepressants**

* [Lithium](#Lithium)\* **(N)** – aim for 0.4-0.8 mmol/L initially
* Lamotrigine (off-label) **(N)**

**Alternative MONOTHERAPIES**

* Moclobemide\* **(N)**
* Phenelzine\* **(N)**
* TriCyclic Antidepressant (TCA) **(N)**

**Antipsychotic AUGMENTATION of partially effective antidepressants**

* [Quetiapine immediate release](#Quetiapine) (150-300 mg/day) (off-label) **(N)** (1st line for psychotic depression)
* [Aripiprazole](#Aripiprazole) (2-20 mg/day) (off-label) **(N)**
* Olanzapine (5-15 mg/day) (off-label) **(N)** (1st line for psychotic depression)
* Risperidone (0.5-3 mg/day) (off-label) **(N)**
* [Amisulpride](#Amisulpride) (low dose: 50 mg/day) (off-label) **(N)**

**PSYCHOTIC DEPRESSION**

## Further Information About Treatment Options



## Consultation and Prescribing Advice General References

 

## Medication reviews

At each review, and at least annually, consider/assess:

* Therapeutic response to the medication including severity & frequency of depressive episodes
* Medication adherence
* Medication side effects (use a validated rating scale, e.g. PhQ9, BDI, HADS, HAM-D, QIDS-SR16, MADRS)
* Comorbid physical and psychiatric conditions
* Use of alcohol and other substances

### Useful links

**NICE Guidelines for Depression**

Depression in adults: recognition and management. 2022. (NICE guideline 222) [www.nice.org.uk/guidance/ng222](http://www.nice.org.uk/guidance/ng222)

Depression in adults with a chronic physical health problem: treatment and management. 2009. (Clinical guideline 91.) [www.nice.org.uk/guidance/cg91](http://www.nice.org.uk/guidance/cg91)

**The Maudsley Prescribing Guidelines**

Taylor, D., Barnes T.R.E. & Young A.H. (2021). Chapter 3 – Depression and anxiety. In The Maudsley Prescribing Guidelines, 14th Edition. London: John Wiley and Sons.

[lib.myilibrary.com/Open.aspx](http://lib.myilibrary.com/Open.aspx?id=786015&src=0) - *You will need an Athens account and login to access this link and can gain one through library services at the Trust if you do not already have one.*

Sections:

* *Antidepressants: relative adverse effects – a rough guide* – Table 3.26, p421-422
* *Antidepressant withdrawal symptoms* – p343-346
* *Serotonin syndrome symptoms* – p337
* *Antidepressants – swapping and stopping* – Table 3.7, p338-341

**Medication Information**

The Choice and Medication website has helpful information in agreeing choice of antidepressant with patients [www.choiceandmedication.org.uk/tees-esk-and-wear-valleys/](http://www.choiceandmedication.org.uk/tees-esk-and-wear-valleys/) and you can print out medication information sheets. It also has information on driving whilst taking medication.

**Switching between antidepressants**

In addition to the guidance embedded above, the NHS Specialist Pharmacy Service provides useful advice here: <https://www.sps.nhs.uk/category/specialty/mental-health-and-illness/>